Michigan Technological University

Dependent Health Insurance Reimbursement Form

(For Supported Graduate Students Only)

Student Name:_____ Semester:_____ Year:_____

Student M#_____

Spouse/Dependents of Supported Graduate Students are eligible for a **reimbursement of 25% of the premium** cost for the Michigan Tech BCBSM Student Health Insurance plan.

Name(s) and relationship and premium paid for enrolled dependents:

Name:_____ Relationship:_____ Premium Paid: $_____

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Name:_____ Relationship:_____ Premium Paid: $_____

Name:_____ Relationship:_____ Premium Paid: $_____

Name:_____ Relationship:_____ Premium Paid: $_____

Total Paid Premium for Enrolled Dependents:

Total: $_____

Please confirm the following:

☐ I am a Supported Graduate Student receiving a 100% premium coverage for the Michigan Tech BCBSM Student Health Insurance.

☐ The dependents listed above are my legal dependents (spouse/child)

You must submit a copy of your receipt of purchase for the Michigan Tech BCBSM Student Health insurance for all dependents listed above to receive the 25% reimbursement. The reimbursement will be made to the Supported Graduate Student listed on this form.

Printed Name: _____

Signature: _____ Date: _____

For Student Insurance Use Only

Verification of Supported Student Status: ☐ **Yes** ☐ **No** Copy of Receipt Received and Verified for all Listed Above: ☐ **Yes** ☐ **No**

Total Reimbursement: $_____ Reimbursement Completion Date: _____ Completed By: _____